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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

STANFORD HEALTH CARE, a
California Nonprofit Corporation,

Plaintiffs,

V.

TRUSTMARK SERVICES
COMPANY, a Delaware for profit
corporation, and DOES 1 THROUGH
25, INCLUSIVE,

Defendant.

Case No.: 5:22-cv-03946-SVK

STANFORD'S **OPPOSITION** TO
DEFENDANT CHEF WAREHOUSE'S
MOTION TO DISMISS PLAINTIFF'S
SECOND AMENDED COMPLAINT

Hearing Date: April 6, 2023

Hearing Time: 1:30 p.m.

Courtroom.: 3

Before: Hon. Richard Seeborg

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MEMORANDUM OF POINTS AND AUTHORITIES

I.

INTRODUCTION AND SUMMARY OF ARGUMENT

Plaintiff Stanford Health Care (“Stanford” or “Plaintiff”) hereby submits the following memorandum of points and authorities in support of its opposition to the motion to dismiss the complaint pursuant to the Federal Rules of Civil Procedure (“FRCP”) 12(b)(6) for failure to state a claim (“Motion to Dismiss”) filed by Chef’s Warehouse (“Chef’s Warehouse” or “Defendant”). Defendant contends that the two causes of action asserted in Stanford’s Second Amended Complaint (“SAC”) must be dismissed for the following reasons: (1) the claims are subject to ERISA and the state law claims must be dismissed under preemption; (2) for breach of implied-in-fact contract, there is an express contract that governs this case; (3) Stanford failed to plead any facts to support its claim of *quantum meruit*; and, (4) Stanford failed to sufficiently plead a claim for violation of the California Business and Professions Code. (Moving Papers p.7:13-26).

II. FACTUAL BACKGROUND

This is an action for payment of amounts due and owing to Stanford in connection with medically necessary care rendered on January 24, 2020 to June 10, 2021 to the patient stated on Exhibit A of the SAC (“Patient”),¹ whose health insurance benefits were sponsored and administered by Defendant. (SAC, ¶ 10).

During the relevant time, Stanford and Chef’s Warehouse had no existing contract, partnership, association, or agreement. However, Chef’s

¹ The patient is only identified by the initials pursuant to the privacy provisions of the Health Insurance Portability & Accountability Act (“HIPAA”), Pub.L. No. 104-191, 110 Stat.1936 (codified as amended in scattered sections of 26 U.S.C. and 42 U.S.C.), and California Constitution, art. 1 Section 1.

Warehouse did have a contract with Trustmark, the co-Defendant.

Stanford verified each Patient's eligibility with Defendant's health plan, communicated with Defendant on a regular basis and concurrently provided clinical reports to Defendant to get authorizations for the services rendered. (SAC, ¶ 16, 20, 22). Stanford timely and properly billed Trustmark, who works with Chef's Warehouse, for the medically necessary services, supplies and/or equipment it rendered to the Patient. (SAC, ¶ 16, 40). However, Defendant neglected to pay Stanford for the services rendered. (SAC, ¶ 17, 29, 40).

In order to recover payment for the medically necessary services rendered to Defendant's member, Stanford filed this lawsuit.

III. STANDARD OF REVIEW

Federal Rule of Civil Procedure 8(a)(2) only requires a complaint to contain "a short plain statement of the claim showing that the pleader is entitled to relief." Thus, a motion under Rule 12(b)(6) "tests the formal sufficiency of the statement of claim for relief." *Fednav Ltd. v. Sterling International*, 572 F. Supp. 1268, 1270 (N.D. Cal. 1983). To survive a motion to dismiss, a complaint must contain sufficient factual material to "state a claim that is plausible on its face." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (2007). In other words, a claim is factually plausible when "the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

Dismissal for failure to state a claim is appropriate only where the complaint lacks a cognizable legal theory or sufficient facts to support a cognizable legal theory. See *Mendiondo v. Centinela Hosp. Medical Center*, 521 F.3rd 1097, 1104 (9th Cir. 2008). When reviewing a motion to dismiss under Fed. R. Civ. P. 12(b)(6), the Court must accept as true all non-conclusory material allegations of

1 the complaint and construe them in the light most favorable to the plaintiff.
 2 *Newman v. Sathyabaglswaran*, 287 F.3d 786, 788 (9th Cir. 2002). The court also
 3 must draw in favor of the plaintiff all reasonable inferences derivable from the
 4 allegations in the complaint. *Pareto v. F.D.I.C.*, 139 F.3d 696, 699 (9th Cir.
 5 1998). Accordingly, if there are two alternative explanations, one advanced by the
 6 defendant and the other advanced by the plaintiff, both of which are plausible, the
 7 “plaintiff’s complaint survives a motion to dismiss under Rule 12(b)(6).” *Starr v.*
 8 *Baca*, 652 F.3d 1202, 1216 (9th Cir. 2011). Moreover, a motion to dismiss under
 9 Rule 12(b)(6) is disfavored and is rarely granted, *Gilligan v. Jamco Develop.*
 10 *Corp.*, 108 F.3d 246, 249 (9th Cir. 1997), and should be granted only where it
 11 appears beyond a reasonable doubt that the plaintiff cannot prove any set of facts
 12 in support of the claim that would entitle the plaintiff to relief. *Conley v. Gibson*,
 13 355 U.S. 41, 45-46 (1957); see also, *Swierkiewicz v. Sorema N.A.*, 534 U.S. 506,
 14 514 (2002)(“A court may dismiss a complaint only if it is clear that no relief could
 15 be granted under any set of facts that could be proved consistent with the
 16 allegations.”)

17
 18 Furthermore, “until an evidentiary hearing or trial on the merits, the
 19 complaint’s uncontroverted factual allegations must be accepted as true, and any
 20 factual conflicts in the parties’ declaration must be resolved in the plaintiff’s
 21 favor.” *Fields v. Sedgwick Assoc. Risks, Ltd.*, 796 F.2d 299, 301 (9th Cir. 1986);
 22 see also *AT&T v. compagnie Bruxelles Lambert*, 94 F.3d 586, 588 (9th Cir. 1996).
 23 (“Conflicts between the evidence must be resolved in the plaintiff’s favor.”) If
 24 material facts are uncontroverted or if the evidence is inadequate, a court may
 25 permit discovery to aid in flushing out the facts. *Data Disc, Inc. v. Systems*
 26 *Technology Associates, Inc.*, 557 F.2d 1280, 1284, 1285 n. 1 (9th Cir. 1977). If the
 27 submitted materials raise issues of credibility or disputed questions of fact, the
 28 district court has the direction to hold an evidentiary hearing in order to resolve the

1 contested issues. *Id.*

2
3 **IV. DEFENDANT'S MOTION TO DISMISS DOES NOT WITHSTAND**
4 **SCRUTINY WITHIN THE FOUR CORNERS OF THE SAC**
5

6 **A. The SAC Pled Sufficient Facts to Allege the Existence of an Implied-In-**
7 **Fact Contract.**
8

9 In Chef's Warehouse's opposition, they state that the facts alleged in
10 the SAC fail to demonstrate that Chef's Warehouse acted in a way evidencing a
11 meeting of the minds to create an implied contract. (Moving Papers p.9:10-11).

12 Stanford's allegations are firmly based on facts supporting mutual
13 intentions to form a valid implied-in-fact contract as explained below.

14 Stanford pleaded: (1) clear contract terms – i.e., Stanford would
15 provide treatment to Defendant' health plan enrollees, and in return, Defendant
16 would pay the charges associated with such treatment, (SAC, ¶ 20-23); (2) that the
17 parties agreed to give each other something of value – i.e., medically necessary
18 services in exchange for monetary payment, (*Id.*); and (3) that the parties agreed to
19 the terms. (SAC, ¶ 26). The mutual agreement or intent may be inferred from the
20 *conduct* of the parties including the act of Stanford providing medical services to
21 the Patient, a Defendant' members; and the act of Defendant making payments on
22 the Patient' claims. *Id.*

23 Stanford amended to add in evidence and claims to show the meeting
24 of the mind needed for an implied-in-fact contract. In *Hoag*, the court found that
25 the defendant's verification of benefits was its manifestation of consent. *Hoag*
26 *Memorial Hosp. v. Managed Care Administrators*, 820 F.Supp 1232, 1237 (C.D.
27 Cal. 1993) (hospital seeking to recover additional payment from the health plan
28 based on an oral verification of benefits). In making that finding the court stated:

1 Due to hospitals' limited funds for indigent care, if a hospital is told
 2 that no coverage exists, the hospital either must obtain funds from
 3 another source or transfer the patient to another facility. Thus, if a
 4 plan administrator or insurance company unqualifiedly verifies
 5 coverage to a health care provider, it should realize that either it is
 6 consenting to the payment of plan benefits or it should "accept [the]
 7 consequences for a false representation of coverage that the provider
 8 reasonably relied upon."

9 *Id. citing Memorial Hosp. System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 246
 10 (5th Cir. 1990).

11 Additionally in *Barlow Respiratory Hospital v. CareFirst of*
 12 *Maryland, Inc.*, Case No. CV-14-01335-MWF-(SSx), 2014 WL 12573394, at 8
 13 (C.D. Cal. June 24, 2014), an implied-in-fact contract was entered into, as a matter
 14 of law, where the medical provider and insurer engaged in direct communications
 15 as to the patient's eligibility, authorization for treatment and the method of
 16 payment for services rendered.

17 Finally, Chef Warehouse's Motion is inaccurate in stating that
 18 authorization is insufficient to create an implied-in-fact contract. (Moving Papers
 19 p. 12:1-3). Despite Chef Warehouse's attempt to mislead the Court, Stanford is
 20 entitled to payment based on pre-authorization and verification of coverage
 21 obtained prior to rendering medical services. The Ninth Circuit recognized that
 22 communication during authorization and verification of coverage may form an
 23 agreement to pay. See *Marin General Hospital v. Modesto & Empire Traction*
 24 *Company*, 581 F.3d 941, 947 (9th Cir. 2009); and *Cedars-Sinai Medical Center v.*
 25 *National League of Postmasters of the U.S.*, 497 F.3d 972, 981 (9th Cir. 2007).
 26 Moreover, California's Eastern District has held that authorizing the medical
 27 services and making partial payment for them were sufficient to form an implied
 28 contract. See *San Joaquin General Hospital v. United Healthcare Ins. Co.*, 2017

1 WL 1093835 at *3 (E.D. Cal. Mar. 22, 2017) citing *Ristau v. Madhvani*, 1991 WL
 2 283666, at *3 (D.D.C. Dec. 20, 1991). Furthermore, in *Tenet Healthsystem Desert,*
 3 *Inc. v. Fortis Ins. Co., Inc.*, 520 F.Supp.2d 1184 (C.D.Cal.2007), the court implied
 4 that where the insurer provided both a pre-authorization and a verification of
 5 coverage in a non-emergency situation, that created an agreement to pay for the
 6 authorized services. *Id.* at 1194.

7
 8 Additionally, this case is different from *Stanford Health Care v. Blue*
 9 *Cross Blue Shield of N. Carolina*. This case deals with multiple patients coming
 10 into Stanford multiple times and no communication from Chef's Warehouse to
 11 change or move said patients. In fact, Chef's Warehouse, though Trustmark, did
 12 not start to send out EOB's until the end of the total treatment of for the patients
 13 mentioned in the Implied in Fact cause of action. (SAC, ¶ 24-25). Stanford
 14 adequately pled that the treatment of those patients multiple times, with repeated
 15 contact with Defendant over it does give rise to mutual assent, as Defendant knew
 16 about the treatment, how much it would cost and did not do anything in response.
 17 Finally, Defendant is asserting that Stanford needs to pled HIPAA confidential
 18 information in the complaint to be able to bring this action of recovery, such as
 19 EOB information, verification and authorization information. This is clearly
 20 against the privacy provisions of the federal Health Insurance Portability &
 21 Accountability Act ("HIPAA") 42 U.S.C. §§1320(d), et seq and 45 C.F.R. §
 22 160.103.

23
 24 For the above stated reasons, Stanford properly pled a cause of action
 25 for breach of implied-in-fact contract. Thus, Chef Warehouse's Motion should be
 26 denied.

B. Stanford’s California Unfair Competition Law Are Not Preempted by ERISA

Defendant’s argument that ERISA preempts a UCL claim by a third-party beneficiary runs headlong into well-established federal precedent. *Memorial Hospital System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 243–246 (5th Cir. 1990) (leading case holding hospital’s claim for deceptive and unfair practices arising from representations regarding coverage not preempted and articulating two-factor test); *The Meadows v. Employers Health Ins.*, 47 F.3d 1006, 1008–1009 (9th Cir. 1995) (adopting the *Memorial Hospital* test and holding ERISA does not preempt “claims by a third-party who sues an ERISA plan not as an assignee of a purported ERISA beneficiary, but as an independent entity claiming damages”).

Moreover, courts around the country have allowed action brought by a health care provider seeking proper reimbursement from a health plan for services rendered. *See Hospice of Metro Denver, Inc. v. Group Health Ins., Inc.*, 944 F.2d 752, 756 (10th Cir. 1991) (“An action brought by a health care provider to recover promised payment from an insurance carrier is distinct from an action brought by a plan participant against the insurer seeking recovery of benefits due under the terms of the insurance plan. Preemption in this case would stretch the ‘connected with or related to’ standard too far.”); *Lordmann Enters. v. Equicor, Inc.*, 32 F.3d 1529, 1534 (11th Cir. 1994) (“[f]inding the *Memorial Hospital* court’s reasoning persuasive, we hold that ERISA does not preempt a health care provider’s negligent misrepresentation claim against an insurer under an ERISA plan”); *see generally Wiggins, Medical Provider Claims: Standing, Assignments, and ERISA Preemption*, 45 J. Marshall L.Rev. 861, 884–888 (2012).

1 **1. Conflict Preemption Under Section 514(A) of ERISA “Does Not**
 2 **Convert A State Claim Into An Action Arising Under Federal**
 3 **Law”**

4 Preemption under section 514(a) is known as "conflict" preemption
 5 under ERISA. *Marin General Hospital v. Modesto & Empire Traction Co.*, 581
 6 F.3d 941, 945 (9th Cir. 2009), Section 514(a) of ERISA provides ERISA shall
 7 "supersede any and all State laws insofar as they may now or hereafter relate to any
 8 employee benefit plan..." 29 U.S.C. § 1144(a). However, "a defense of conflict
 9 preemption under § 514(a) does *not* confer federal question jurisdiction on a
 10 federal district court." *Id.* at 946 (emphasis added). More specifically, conflict
 11 preemption "does not convert a state claim into an action arising under federal
 12 law". *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 64 (1987); see also
 13 *Marin General Hospital*, supra, 582 F.3d at 945. Furthermore, the *Morris* court
 14 noted that courts have recognized that 'relatively commonplace' lawsuits against
 15 ERISA plans for "'run-of-the-mill state-law claims such as unpaid rent, failure to
 16 pay creditors, or even torts committed by an ERISA plan' are not preempted even
 17 though they 'obviously affect[] and involve[] ERISA plans and their trustees.'" *Morris B. Silver M.D., Inc. v. Int'l Longshore and Warehouse Union-Pacific*
 18 *Maritime Assoc. Welfare Plan*, 2 Cal.App. 5th 793, 802 (2016). See also *Mackey*
 19 *v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 833 (1988) (holding
 20 that "lawsuits against ERISA plans for run-of-the-mill state-law claims such as
 21 unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan"
 22 are not preempted even though they "obviously affect[] and involve[] ERISA
 23 plans and their trustees.").

1 **2. Complete Preemption Under § 502(a) of ERISA Does Not Extend**
 2 **to Stanford's Claims Because They Fall Outside of The**
 3 **Traditional Relationship Governed By ERISA**

4 Complete preemption under § 502(a) is "really a jurisdictional rather
 5 than a preemption doctrine, [as it] confers exclusive federal jurisdiction in certain
 6 instances where Congress intended the scope of a federal law to be so broad as to
 7 entirely replace any state-law claim." *Marin General Hospital*, supra, 581 F.3d at
 8 945. § 502(a)(1)(B) provides that "[a] civil action may be brought—(1) by a
 9 participant or beneficiary—...(2) to recover benefits due to him under the terms of
 10 his plan, to enforce his rights under the terms of the plan, or to clarify his rights to
 11 future benefits under the terms of the plan." 29 U.S.C. § 1132(a).

12
 13 The test for complete preemption of a state claim under § 502(a) is
 14 whether "(1) 'an individual, at some point in time, could have brought [the] claim
 15 under ERISA § 502(a)(1)(B),' *and* (2) 'where there is no other independent legal
 16 duty that is implicated by a defendant's actions.'" *Marin General Hospital*, supra,
 17 581 F.3d at 946, (citing *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004))
 18 (emphasis added). "The two prong test of *Davila* is in the conjunctive. As such, a
 19 state-law cause of action is preempted by § 502(a)(1)(B) only if **both** prongs of the
 20 test are satisfied." *Marin General Hospital*, supra, 581 F.3d at 947 (emphasis
 21 added). In this case, neither prong is satisfied.

22
 23 **a. The First Prong of Davila Is Not Satisfied**

24
 25 First, as in *Marin General Hospital*, Stanford could not have brought
 26 its state-law claim under Section 502(a)(1)(B) of ERISA because it does not have
 27 statutory standing to sue under ERISA. Stanford has no standing under ERISA
 28 since it is not a participant, beneficiary, employer or fiduciary of an ERISA plan,

1 nor is it acting in the capacity of a public official authorized to bring such an
2 action. 29 U.S.C. § 1132(a). No other person has standing to maintain an ERISA
3 action. *Harris v. Provident Life & Accident Insurance Company*, 26 F.3d 930, 933
4 (9th Cir. 1994) citing *Franchise Tax Board v. Construction Laborers Vacation*
5 *Trust*, 463 U.S. 1, 27 (1983). Therefore, any argument that Stanford’s state law
6 causes of action are preempted based on ERISA is a legal impossibility since
7 Stanford lacks standing to bring an action on ERISA grounds.

8
9 Second, ERISA preemption further does not apply since Stanford’s
10 causes of action are not claims that the Patients could have alleged against the
11 Defendants. The state law causes of action of Stanford, as a third-party medical
12 provider, seeking damages relating to the authorized medical services are not
13 preempted by ERISA. See *The Meadows*, supra, 47 F.3d at 1008–1009 (adopting
14 the *Memorial Hospital* test and holding ERISA does not preempt “claims by a
15 third-party who sues an ERISA plan not as an assignee of a purported ERISA
16 beneficiary, but as an independent entity claiming damages”).

17
18 In the case at hand, the SAC’s causes of action: (1) breach of implied
19 in fact contract, (2) *quantum meruit* and, (3) violation of California’s Unfair
20 Competition Law, are the result of the Defendant’s conduct with Stanford. The
21 Patients simply could not bring these causes of action either by themselves or
22 through their assignees. Rather, these causes of action arose from the operation of
23 Stanford and its interaction with the Defendant as commercial entities having
24 commercial dealings with one another. Such a creditor-debtor relationship is not
25 one that is preempted by ERISA.

26
27 It should be noted that in limited circumstances, the Ninth Circuit has
28 recognized “derivative standing”—the validity of benefit plan assignments to

1 health care providers. See *Misic v. Building Servs. Employee Health and Welfare*
 2 *Trust*, 789 F.2d 1374 (9th Cir. 1986) (permitting derivative standing where
 3 physician-plaintiff did not have independent contractual relationship with the
 4 plan). *Eden Surgical Ctr. v. B. Braun Med., Inc.*, 420 F. Appx 696, 697 (9th Cir.
 5 2011) (holding that “health care providers may obtain derivative standing to assert
 6 claims under ERISA by securing an assignment of the party with standing's
 7 rights.”). However, Judge Thelton Henderson dictated that an enrollee's
 8 assignment of its right to payment to a provider is “of no consequence” when it is
 9 the *amount* of the payment being disputed and *not* the right to payment. *John Muir*
 10 *Health v. Cement Masons Health & Welfare Trust Fund*, 69 F.Supp.3d 1010, 1017
 11 (N.D. Cal. 2014) (emphasis added).

12
 13 By citing only distinguishable cases, Defendant’s seek to have the
 14 Court assume that Stanford’s s claims are preempted by ERISA based on some
 15 impossible assignment theory. However, Stanford has not brought an action to
 16 recover plan benefits or the right to payment but rather to recover *damages* arising
 17 from state-law theories of recovery. [SAC, ¶ 8.] Nowhere in the SAC does
 18 Stanford allege that it is suing based on an assignment of benefits from the patient
 19 at issue, or otherwise standing in the shoes of the patient in seeking recovery from
 20 the Defendants. Nevertheless, even if it had, *Marin General Hospital* makes it
 21 clear that the hospital has the right to sue upon an independent obligation, which is
 22 what it is doing here. Additionally, mere assignment of benefits to plaintiffs does
 23 not prevent them from bringing a separate action based on a different legal
 24 obligation. *Marin General Hospital*, supra, 581 F.3d at 948.

25
 26 Here, Stanford is not stepping into the shoes of the plan beneficiary
 27 and is not bringing the action as a plan beneficiary against the Defendants.
 28 Accordingly, the *Davila* first prong is not satisfied.

b. The Second Prong of Davila Is Not Satisfied

The second prong of the Davila test is also not satisfied: Stanford's SAC is based upon independent state law legal duties to recover damages based on the Defendants' breach of implied in fact contract, violation of California's Unfair Competition Law and *quantum meruit*.

1. There is no relevant contract between Stanford and Chef's Warehouse

Chef's Warehouse alleges that there is an applicable contract. (Moving Papers p. 12:6, 15-18; 16:16-17, 22-25). It leaves out any analysis about how this contract binds Stanford – as Stanford is not a party or signatory to this contract. Chef's Warehouse seems to be trying to hold Stanford to the terms of a contract between Chef's Warehouse and Trustmark. As Stanford was never a party to this contract, it does not preempt the causes of action in this case.

C. The SAC Pled Sufficient Facts to Allege a *Quantum Meruit* Cause of Action Because Defendant Both Requested And Benefited from the Services Rendered by Stanford

Defendant motion to dismiss as to the third cause of action rests upon the fact that Stanford did not properly allege Defendant made a request for services and that the services rendered benefited Defendant (Moving Papers p. 14:12-28; 15:1-3). However, under California law a formal request for service is not required, especially in situations pertaining to emergency medical services rendered to a payor's beneficiary. There is one claim at issue that specifically involves emergency medical services as was the case with Patient 8 (cite to SAC).

1 . As a member of the Defendant's health plan, who pays premiums
2 for such medical coverage, Patient 8 benefited from the medically necessary
3 services rendered by Stanford. By providing such medically necessary care to
4 Patient 8, Stanford conferred a benefit upon Chef's Warehouse because it allowed
5 Chef's Warehouse to make good on promises made to their beneficiaries that their
6 beneficiaries and their families would receive and be covered for medically
7 necessary treatment and would shield their beneficiaries from the bulk of the
8 financial responsibility for payment for medical care received by them and their
9 families. For example, when the plan beneficiaries pay premiums, Chef's
10 Warehouse becomes obligated to accept, process, arrange for, and/or pay claims
11 for the value of medical services rendered to their beneficiaries and/or their
12 families. Thus, by fulfilling its coverage obligations to its plan beneficiaries and
13 their families, Chef's Warehouse does not have to face allegations that they
14 breached any duties owed to the plan beneficiaries and their families. In other
15 words, by rendering medical care to Patient 8 in conjunction with Chef's
16 Warehouse's authorization, Stanford helped Chef's Warehouse fulfill its legal duty
17 as explained above. Thus, a benefit accrued to Chef's Warehouse and Stanford is
18 entitled to the reimbursement of the reasonable value of the services. The
19 reasonable value of the services is the total billed charges.

20
21 Chef's Warehouse is also trying to impose a contract discount on
22 Stanford, which was never offered or agreed to by Stanford. As Stanford has no
23 contract with Chef's Warehouse, Stanford is not asserting anything under the
24 referred Plan in the Moving Papers. (Moving Papers p.15:4-10). Still, Chef's
25 Warehouse continuously tries to push contract terms onto Stanford who is not a
26 signatory to any contract. Whatever terms are under the Plan Document is of no
27 relevance to this case, except as to the benefit received. Additionally, as this was
28 an emergency service, Chef's Warehouse benefited from Stanford keeping Patient

1 8 alive and well, thus that they can continue to be a member and pay for their
 2 insurance under Chef's Warehouse. Chef's Warehouse main argument is that they
 3 receive no benefit from their members being treated, which brings into question
 4 what their responsibility is as an insurer if not to help provide and pay for
 5 treatment for their members.

6
 7 Under California law, hospitals are required to provide necessary
 8 health care and insurers are required to pay the customary and reasonable value.
 9 *Cal. Health & Safety Code* §§1317 et seq. Chef's Warehouse admits, through the
 10 Plan Document a contradictory assertion that although it covers the patient's
 11 treatment, the patient derived no benefits from this care. This is a disingenuous
 12 argument. As Stanford is not a party to the Plan Document, Plaintiff is entitled to
 13 the reasonable and customary value of the treatment provided, without a discount.
 14 And there is no argument towards whether a benefit was received, as the Plan
 15 Document acknowledges that this treatment would be paid for under the
 16 Document.

17
 18 Despite Defendant's attempt to dodge its financial obligation to
 19 reimburse Stanford for the emergency services rendered to Defendant's members,
 20 California Courts have consistently recognized that reimbursement for emergency
 21 services to a noncontracted provider shall be at the "reasonable and customary
 22 value." (*Children's Hospital Central California v. Blue Cross of California*, 226
 23 Cal.App.4th 1260, 1272 (2014) (finding Cal. Code Regs. tit. 28, §
 24 1300.71(a)(3)(B) defines 'Reimbursement of a Claim' by a health plan to a
 25 noncontracted emergency provider as "the payment of the reasonable and
 26 customary value for the health care services rendered."')).

27
 28 "If a hospital or other medical provider believes that the amount of

1 reimbursement it has received from a health [] plan is below the “reasonable and
 2 customary value” of the emergency services it has provided, the hospital or
 3 provider may assert a quantum meruit claim against the plan to recover the
 4 shortfall. *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 213-214,
 5 221, 31 Cal.Rptr.3d 688 (Bell); *Prospect Medical*, supra, 45 Cal.4th at p. 505, 87
 6 Cal.Rptr.3d 299, 198 P.3d 86; *Children's Hospital Central California v. Blue*
 7 *Cross of California* (2014) 226 Cal.App.4th 1260, 1273, 172 Cal.Rptr.3d 861
 8 (*Children's Hospital*.) As the plaintiff in a quantum meruit lawsuit, the hospital or
 9 provider bears the burden of establishing that the plan's reimbursement was less
 10 than the “reasonable and customary value” of its services. (*Children's Hospital*, at
 11 p. 1274, 172 Cal.Rptr.3d 861.)” (*Long Beach Mem'l Med. Ctr. v. Kaiser Found.*
 12 *Health Plan, Inc.*, 71 Cal. App. 5th 323, 335, 286 Cal. Rptr. 3d 419, 426–27
 13 (2021)).

14
 15 It is unreasonable that Chef’s Warehouse’s can claim under *quantum*
 16 *meruit* that it no payment should be made even if Patient 8 made 11 visits to
 17 Stanford. Chef’s Warehouse could still claim, as it does here, that it never
 18 requested services. And yet, \$478,797.96 worth of services would remain unpaid.

19
 20 This goes against public policy in keeping hospital doors open. And
 21 yet, it is a central point in Chef’s Warehouse’s argument. The real dispute in this
 22 case is over the “the reasonable value of the services,” which is the “[t]he measure
 23 of recovery in quantum meruit.” (*Children's Hosp. Cent. California v. Blue Cross*
 24 *of California*, 226 Cal. App. 4th 1260, 1274 (2014)). But Chef’s Warehouse is
 25 trying to finagle out of *quantum meruit* elements because it knows “reasonable
 26 value” issues are not at the motion to dismiss stage. No market participant believes
 27 hospitals are in the business of providing gratuitous services, and certainly not to
 28 insured patients, on their third go-round, when hospitals obtained verification and

1 authorization for services.

2
3 In any event, Chef's Warehouse arguments also fail on their own
4 terms.

5
6 **1. Stanford is not a party to any alleged ERISA covered Plan**
7 **agreement between Chef's Warehouse and the Patient.**
8

9 Ignoring the throat-clearing recitations of law, the entirety of this
10 argument is contained in a single sentence: "Plaintiff's quantum meruit claim is
11 barred because a valid, written contract (the Plan Document) established the terms
12 for the reimbursement of Plaintiff for treatment of the Patients by the Health Plan"
13 (Moving Papers p. 16:22-24). But Stanford is not a party to any such contract,
14 which is between the Plan, both Defendants and Patient 8. This argument has no
15 merit.

16
17 **2. Chef's Warehouse acquiesced in Stanford's provision of services,**
18 **which is all that quantum meruit requires.**
19

20 While it is true that a *quantum meruit* plaintiff must show "either an
21 express or implied request" for services (*Day v. Alta Bates Med. Ctr.*, 98
22 Cal.App.4th 243, 248 (2002)), that very same case makes clear that the "implied
23 request" can be satisfied by "acquiesce[ing]" in them. (*Id.* at p. 249.) The case
24 *Day* cites to *Producers Cotton Oil Co. v. Amstar Corp.*, 197 Cal.App.3d 638
25 (1988), which involved a farmer, the buyer of his crops, the farmer's lender, and an
26 independent contractor who harvested the farmer's crops. The buyer paid the
27 harvester to bring in the crops, but the lender claimed a superior security interest
28 and the buyer ended up losing the money it fronted so the crops could be

1 harvested. (*Id.* at pp. 643-645.) The lender knew the buyer was fronting these
 2 costs and stood mute. (*Id.* at pp. 658-59.) The Court of Appeal concluded the
 3 lender had acquiesced in the buyer's payment to the harvester, even though the
 4 harvester and the lender had nothing to do with one another. (*Ibid.*) That is to say,
 5 a cash payment to a third-party with no relation to the defendant was deemed
 6 "requested," or more accurately, acquiesced in. Thus, the hornbook law in
 7 California is: "[W]here a useful service of a type usually charged for is performed
 8 for another with the latter's knowledge, a promise to pay its reasonable value is
 9 implied from the fact that he or she expressed no dissent." (55 Cal. Jur. 3d
 10 Restitution § 57.)

11
 12 California courts applying California law define "request" for
 13 purposes of *quantum meruit* to include accepting services silently or otherwise
 14 simply acquiescing in services one knows cost money (*Producers Cotton Oil Co.*
 15 *v. Amstar Corp.*, 197 Cal.App.3d 638, 658-59 (1988); 55 Cal. Jur. 3d Restitution §
 16 57); and some federal courts applying California law have let identical claims
 17 proceed (*San Joaquin Gen. Hosp. v. United Healthcare Insurance Co.*, No. 2:16–
 18 cv–01904–KJM–EFB, 2017 WL 1093835(E.D. Cal. Mar. 23, 2017)), at the least
 19 past the motion to dismiss/demurrer stage (*Stanford Hosp. and Clinics v.*
 20 *Multinational Underwriters, Inc.*, No. C–07–05497-JF-RS, 2008 WL
 21 5221071(N.D. Cal. Dec. 12, 2008)), since discovery may reveal more about how
 22 Chef's Warehouse views its authorizations in practice. "Quantum meruit refers to
 23 the well-established principle that "the law implies a promise to pay for services
 24 performed under circumstances disclosing that they were not gratuitously
 25 rendered." [Citation.] To recover in quantum meruit, a party need not prove the
 26 existence of a contract [citations], but it must show the circumstances were such
 27 that "the services were rendered under some understanding or expectation of both
 28 parties that compensation therefor was to be made." ' [Citation.]" (*1128 *Miller v.*

1 *Campbell, Warburton, Fitzsimmons, Smith, Mendel & Pastore* (2008) 162
 2 Cal.App.4th 1331, 1344 [76 Cal.Rptr.3d 649].) “The underlying idea behind
 3 quantum meruit is the law's distaste for unjust enrichment. If one has received a
 4 benefit which one may not justly retain, one should ‘restore the aggrieved party to
 5 his [or her] former position by return of the thing or its equivalent in money.’
 6 [Citation.]” (*Maglica v. Maglica* (1998) 66 Cal.App.4th 442, 449 [78 Cal.Rptr.2d
 7 101], italics omitted.) “ ‘The measure of recovery in quantum meruit is the
 8 reasonable value of the services rendered provided they were of direct benefit to
 9 the defendant.’ [Citations.]” (*Ibid.*) In other words, quantum **781 meruit is
 10 equitable payment for services already rendered.” *E. J. Franks Construction, Inc.*
 11 *v. Sahota*, 226 Cal.App.4th 1123, 1127 (2014).

12
 13 The choice before the Court is clear: an audaciously overbroad
 14 statement of law that would allow health plans to skip out on the bill entirely or a
 15 consistent application of California *quantum meruit* law. Although Chef’s
 16 Warehouse paid a small amount in this case, eliminating potential *quantum meruit*
 17 liability as a matter of law because patients are the ones who physically appear in
 18 doctors’ offices (rather than their insurers) will guarantee the next non-contracted
 19 insurer pays even less.

20
 21 Finally, this case is wholly separate from *Stanford Health Care v.*
 22 *Blue Cross Blue Shield of North Carolina, Inc.*. That case did not involve
 23 emergency care, in fact the Court did not rule on what would happen in emergency
 24 care situations. “The Court notes that based on Stanford's pleadings, the situation it
 25 raises is a hypothetical not before the Court, since Stanford has not adequately pled
 26 that any of the specific services in this case involved emergency care or an
 27 unconscious patient. See FAC, ECF No. 13 ¶ 21 (generally pleading that the
 28 services at issue included “emergency services” without specifying the relevant

patients or claims).” *Stanford Health Care v. Blue Cross Blue Shield of N. Carolina, Inc.*, No. 21-CV-04598-BLF, 2022 WL 195847, at *10 (N.D. Cal. Jan. 21, 2022).

V.

**IF DEFENDANT’S MOTION IS GRANTED, STANFORD
RESPECTFULLY REQUESTS THE COURT GRANT IT LEAVE TO
AMEND**

Stanford believes it sufficiently pled each cause of action alleged in its SAC based upon state law obligations between it and Defendant, independent of the terms of Patient’s health plan. However, in the event the Court finds otherwise, Stanford respectfully requests the Court grant it leave to amend.

Rule 15(a) declares that leave to amend 'shall be freely given when justice so requires'; this mandate is to be heeded. See generally, 3 Moore, Federal Practice (2d ed. 1948), 15.08, 15.10. If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits. In the absence of any apparent or declared reason—such as undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party by virtue of allowance of the amendment, futility of amendment, etc.—the leave sought should, as the rules require, be 'freely given.' Of course, the grant or denial of an opportunity to amend is within the discretion of the District Court, but outright refusal to grant the leave without any justifying reason appearing for the denial is not an exercise of discretion; it is merely abuse of that discretion and inconsistent with

the spirit of the Federal Rules.
Foman v. Davis, 371 U.S. 178, 182 (1962).

VI.
CONCLUSION

For all the foregoing reasons, Stanford respectfully requests the Court deny Defendant's Motion to Dismiss. In the event the Court grants any portion of the Motion to Dismiss, Stanford respectfully requests that it be granted leave to file a Second Amended Complaint.

Dated: 10 March 2023

LAW OFFICES OF STEPHENSON,
ACQUISTO & COLMAN, INC.

Venetia Byars

VENETIA BYARS
Attorney for
STANFORD HEALTH CARE

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PROOF OF SERVICE

I am employed in the county of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is 303 North Glenoaks Boulevard, Suite 700, Burbank, California 91502-3226. On 10 March 2023, I served the foregoing document(s) entitled:

STANFORD'S OPPOSITION TO DEFENDANT CHEF WAREHOUSE'S MOTION TO DISMISS PLAINTIFF'S SECOND AMENDED COMPLAINT

by placing a true copy thereof enclosed in a sealed envelope addressed per the attached Service List.

[] BY MAIL: I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with the United States Postal Service on that same day with postage thereon fully prepaid at Burbank, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit. [C.C.P. 1013a(3); F.R.C.P. 5(b)]

[] BY FEDERAL EXPRESS: I caused such envelope(s), with overnight Federal Express Delivery Charges to be paid by this firm, to be deposited with the Federal Express Corporation at a regularly maintained facility on the aforementioned date. [C.C.P. 1013(c) 1013(d)]

[] BY PERSONAL SERVICE: I caused the above-stated document(s) to be served by personally delivering a true copy thereof to the individuals identified above. [C.C.P. 1011(a); F.R.C.P. 5(b)]

[] BY EXPRESS MAIL: I caused such envelope(s), with postage thereon fully prepaid and addressed to the party(s) shown above, to be deposited in a facility operated by the U.S. Postal Service and regularly maintained for the receipt of Express Mail on the aforementioned date. [C.C.P. 1013(c)]

[] BY TELECOPIER: Service was effected on all parties at approximately ____:____ am/pm by transmitting said document(s) from this firm's facsimile machine (818/559-4477) to the facsimile machine number(s) shown above. Transmission to said numbers was successful as evidenced by a Transmission Report produced by the machine indicating the documents

1 had been transmitted completely and without error. C.R.C. 2008(e), Cal.
2 Civ. Proc. Code § 1013(e).

3 [X] BY ELECTRONIC SERVICE: By emailing true and correct copies to the
4 persons at the electronic notification address(es) shown on the
5 accompanying service list. The document(s) was/were served electronically
and the transmission was reported as complete and without error.

6 [X] State: I declare under penalty of perjury under the laws of the State of
7 California that the above is true and correct.

8 Executed on 10 March 2023 in Burbank, California.

9 *maria torres.*

10
11 _____
12 MARIA TORRES

13 **SERVICE LIST**

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